Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VA North Florida/South Georgia HCS (VAMC Gainesville - 573 and VAMC Lake City - 573A4)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 6200

2. Estimated Number of Veterans who are Chronically Homeless: 1798

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 6200 (estimated number of homeless veterans in service area) **x chronically homeless rate (29 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	637	150
Transitional Housing Beds	309	75
Permanent Housing Beds	563	150

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 4

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	HCHV will continue to work through the coalitions to make this issue a priority for funding.
Dental care	HCHV will work to ensure that all homeless veterans in our program have access to VA dental care if needed.
Immediate shelter	HCHV is participating in local development of 10-year-plan to end homelessness. A proposal has been submitted for a 60-bed domiciliary.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **83** **Non-VA staff Participants: 85.0%**
Homeless/Formerly Homeless: **33.7%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.22	.0%	3.47
Food	3.69	11.0%	3.80
Clothing	3.39	3.0%	3.61
Emergency (immediate) shelter	2.72	26.0%	3.33
Halfway house or transitional living facility	2.82	19.0%	3.07
Long-term, permanent housing	2.19	39.0%	2.49
Detoxification from substances	3.27	8.0%	3.41
Treatment for substance abuse	3.25	21.0%	3.55
Services for emotional or psychiatric problems	3.1	14.0%	3.46
Treatment for dual diagnosis	3.0	8.0%	3.30
Family counseling	2.70	1.0%	2.99
Medical services	3.56	11.0%	3.78
Women's health care	2.83	3.0%	3.23
Help with medication	3.40	3.0%	3.46
Drop-in center or day program	2.60	1.0%	2.98
AIDS/HIV testing/counseling	3.32	3.0%	3.51
TB testing	3.42	.0%	3.71
TB treatment	3.18	.0%	3.57
Hepatitis C testing	3.48	.0%	3.63
Dental care	1.86	37.0%	2.59
Eye care	2.74	.0%	2.88
Glasses	2.86	3.0%	2.88
VA disability/pension	3.13	8.0%	3.40
Welfare payments	2.60	.0%	3.03
SSI/SSD process	2.77	10.0%	3.10
Guardianship (financial)	2.65	4.0%	2.85
Help managing money	2.62	1.0%	2.87
Job training	2.72	8.0%	3.02
Help with finding a job or getting employment	2.93	15.0%	3.14
Help getting needed documents or identification	3.21	3.0%	3.28
Help with transportation	2.97	3.0%	3.02
Education	2.71	11.0%	3.00
Child care	2.25	1.0%	2.45
Legal assistance	2.48	4.0%	2.71
Discharge upgrade	2.60	.0%	3.00
Spiritual	3.29	3.0%	3.36
Re-entry services for incarcerated veterans	2.55	8.0%	2.72
Elder Healthcare	2.71	8.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.54
Co-location of Services - Services from the VA and your agency provided in one location.	2.00
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.87
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.29
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.57
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.61
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.87
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.17
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.93
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.69
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.69
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.95

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.58
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.57

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAH Tampa, FL - 673

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 4900

2. Estimated Number of Veterans who are Chronically Homeless: 1421

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 4900 (estimated number of homeless veterans in service area) **x chronically homeless rate (29 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	490	49
Transitional Housing Beds	341	0
Permanent Housing Beds	246	974

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 35

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue to partner with community agencies and the Homeless Coalition of Hillsborough County for funds for expansion of permanent housing projects.
Detoxification from substances	Advocate for VAH to develop a program to detox veterans.
Help finding a job or getting employment	CWT will become more accessible. Eligibility has already changed to enable veterans to work part-time. Other performance improvements are in process to better serve veterans.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **27 Non-VA staff Participants: 68.4%**
Homeless/Formerly Homeless: **40.7%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.92	4.0%	3.47
Food	3.92	22.0%	3.80
Clothing	3.75	4.0%	3.61
Emergency (immediate) shelter	3.40	22.0%	3.33
Halfway house or transitional living facility	3.00	13.0%	3.07
Long-term, permanent housing	2.48	30.0%	2.49
Detoxification from substances	3.48	26.0%	3.41
Treatment for substance abuse	3.80	30.0%	3.55
Services for emotional or psychiatric problems	3.3	.0%	3.46
Treatment for dual diagnosis	3.0	.0%	3.30
Family counseling	2.92	.0%	2.99
Medical services	3.72	.0%	3.78
Women's health care	3.17	.0%	3.23
Help with medication	3.48	4.0%	3.46
Drop-in center or day program	2.13	13.0%	2.98
AIDS/HIV testing/counseling	3.57	.0%	3.51
TB testing	3.83	4.0%	3.71
TB treatment	3.70	.0%	3.57
Hepatitis C testing	3.88	.0%	3.63
Dental care	1.96	22.0%	2.59
Eye care	2.54	13.0%	2.88
Glasses	2.68	9.0%	2.88
VA disability/pension	3.13	.0%	3.40
Welfare payments	2.67	.0%	3.03
SSI/SSD process	3.08	.0%	3.10
Guardianship (financial)	2.48	.0%	2.85
Help managing money	2.82	.0%	2.87
Job training	2.92	22.0%	3.02
Help with finding a job or getting employment	3.04	35.0%	3.14
Help getting needed documents or identification	3.48	4.0%	3.28
Help with transportation	3.25	9.0%	3.02
Education	2.92	.0%	3.00
Child care	2.04	4.0%	2.45
Legal assistance	2.50	.0%	2.71
Discharge upgrade	2.96	.0%	3.00
Spiritual	3.52	.0%	3.36
Re-entry services for incarcerated veterans	2.83	9.0%	2.72
Elder Healthcare	2.43	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.18
Co-location of Services - Services from the VA and your agency provided in one location.	1.36
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.40
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.50
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.40
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.40
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.00
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.50
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.10
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.30
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.50
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.60

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.50
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.57

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Bay Pines - 516

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 1500

2. Estimated Number of Veterans who are Chronically Homeless: 405

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 1500 (estimated number of homeless veterans in service area) **x chronically homeless rate (27 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	800	500
Transitional Housing Beds	200	200
Permanent Housing Beds	100	500

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 3

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Participate in local, city, and county meetings in regards to committee involvement in dealing with the homeless. Continue to give community agencies information on VA Grant and Per Diem applications and city and county grants available.
Dental care	Goal is to assist veterans with dental needs in the DCHV and Grant and Per Diem program when they become eligible after 60 days of admission.
Help getting needed documents or identification	Bay Pines VAMC does not assist with securing needed documentation or getting identification. We contact community resources locally to assist veterans to get necessary documentations.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **28** **Non-VA staff Participants: 85.7%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.38	.0%	3.47
Food	3.88	13.0%	3.80
Clothing	3.73	4.0%	3.61
Emergency (immediate) shelter	2.62	63.0%	3.33
Halfway house or transitional living facility	2.69	17.0%	3.07
Long-term, permanent housing	2.04	33.0%	2.49
Detoxification from substances	3.08	8.0%	3.41
Treatment for substance abuse	3.08	17.0%	3.55
Services for emotional or psychiatric problems	3.2	8.0%	3.46
Treatment for dual diagnosis	3.1	.0%	3.30
Family counseling	3.15	.0%	2.99
Medical services	3.54	13.0%	3.78
Women's health care	3.32	.0%	3.23
Help with medication	3.08	8.0%	3.46
Drop-in center or day program	3.12	.0%	2.98
AIDS/HIV testing/counseling	2.81	4.0%	3.51
TB testing	3.08	.0%	3.71
TB treatment	3.15	.0%	3.57
Hepatitis C testing	2.96	8.0%	3.63
Dental care	2.08	25.0%	2.59
Eye care	2.15	.0%	2.88
Glasses	2.23	.0%	2.88
VA disability/pension	3.19	8.0%	3.40
Welfare payments	2.52	4.0%	3.03
SSI/SSD process	2.62	.0%	3.10
Guardianship (financial)	2.48	.0%	2.85
Help managing money	2.46	4.0%	2.87
Job training	3.00	4.0%	3.02
Help with finding a job or getting employment	2.85	21.0%	3.14
Help getting needed documents or identification	2.85	8.0%	3.28
Help with transportation	2.52	17.0%	3.02
Education	2.92	.0%	3.00
Child care	2.08	4.0%	2.45
Legal assistance	2.60	.0%	2.71
Discharge upgrade	2.65	.0%	3.00
Spiritual	3.28	.0%	3.36
Re-entry services for incarcerated veterans	2.31	4.0%	2.72
Elder Healthcare	2.63	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.68
Co-location of Services - Services from the VA and your agency provided in one location.	2.55
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.71
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.14
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.55
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.76
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.85
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.10
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.19
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.81
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.71
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.86

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.29
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.63

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Miami, FL - 546

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 5394

2. Estimated Number of Veterans who are Chronically Homeless: 1564

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 5394 (estimated number of homeless veterans in service area) **x chronically homeless rate (29 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	2120	1150
Transitional Housing Beds	1874	10
Permanent Housing Beds	1700	50

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 2

3. CHALENG Point of Contact Action Plan for FY 2005

Transportation	Transportation to/from medical appointments is necessary to meet primary care performance measures. Vets require transportation for job interviews. Local counties will receive increase in Patriot Bus passes.
Treatment for substance abuse	LCSW/Outreach clinician will network with community agencies to decrease waiting list time at VA. Additional aftercare programs, relapse prevention, and educational needs are provided via Miami VA OSAC program.
Help getting needed documents or identification	In Miami-Dade, the Calvary Church has agreed to provide funds for veterans to obtain photo IDs, birth certificates, and drivers licenses. HCHV coordinator will continue to network with community agency.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **43** **Non-VA staff Participants: 81.4%**
Homeless/Formerly Homeless: **14.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.12	8.0%	3.47
Food	3.56	8.0%	3.80
Clothing	3.21	3.0%	3.61
Emergency (immediate) shelter	3.09	32.0%	3.33
Halfway house or transitional living facility	3.07	8.0%	3.07
Long-term, permanent housing	2.35	32.0%	2.49
Detoxification from substances	3.16	16.0%	3.41
Treatment for substance abuse	3.24	27.0%	3.55
Services for emotional or psychiatric problems	3.3	11.0%	3.46
Treatment for dual diagnosis	3.2	14.0%	3.30
Family counseling	3.00	5.0%	2.99
Medical services	3.81	5.0%	3.78
Women's health care	3.57	.0%	3.23
Help with medication	3.67	.0%	3.46
Drop-in center or day program	3.00	5.0%	2.98
AIDS/HIV testing/counseling	3.95	.0%	3.51
TB testing	3.81	.0%	3.71
TB treatment	3.68	.0%	3.57
Hepatitis C testing	3.80	.0%	3.63
Dental care	2.40	22.0%	2.59
Eye care	3.05	.0%	2.88
Glasses	2.98	3.0%	2.88
VA disability/pension	3.90	5.0%	3.40
Welfare payments	3.26	.0%	3.03
SSI/SSD process	3.53	3.0%	3.10
Guardianship (financial)	3.03	5.0%	2.85
Help managing money	2.79	11.0%	2.87
Job training	3.12	14.0%	3.02
Help with finding a job or getting employment	3.23	8.0%	3.14
Help getting needed documents or identification	3.10	3.0%	3.28
Help with transportation	3.05	16.0%	3.02
Education	2.93	11.0%	3.00
Child care	2.66	5.0%	2.45
Legal assistance	2.83	5.0%	2.71
Discharge upgrade	3.10	.0%	3.00
Spiritual	3.28	.0%	3.36
Re-entry services for incarcerated veterans	2.93	14.0%	2.72
Elder Healthcare	3.15	5.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.85
Co-location of Services - Services from the VA and your agency provided in one location.	2.38
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.00
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.44
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.74
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.74
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.00
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.12
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.15
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.68
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.85
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.91

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.71
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.83

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC West Palm Beach, FL - 548

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 1400

2. Estimated Number of Veterans who are Chronically Homeless: 294

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 1400 (estimated number of homeless veterans in service area) **x chronically homeless rate (21 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	10	750
Transitional Housing Beds	30	30
Permanent Housing Beds	0	25

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 5

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	VA will collaboratively work with local agencies to establish a business dealing to access existing community permanent supportive housing.
Help finding a job or getting employment	Collaborate work with CWT program at VA, workforce development and the Community Justice Service Center.
Immediate shelter	Continue working with community agencies and political bodies to establish immediate shelter.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **17** **Non-VA staff Participants: 88.2%**
Homeless/Formerly Homeless: **5.9%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.63	.0%	3.47
Food	3.94	.0%	3.80
Clothing	3.75	8.0%	3.61
Emergency (immediate) shelter	2.69	31.0%	3.33
Halfway house or transitional living facility	3.13	15.0%	3.07
Long-term, permanent housing	2.07	69.0%	2.49
Detoxification from substances	3.50	8.0%	3.41
Treatment for substance abuse	3.31	15.0%	3.55
Services for emotional or psychiatric problems	3.4	.0%	3.46
Treatment for dual diagnosis	3.3	.0%	3.30
Family counseling	2.69	15.0%	2.99
Medical services	3.81	15.0%	3.78
Women's health care	2.81	.0%	3.23
Help with medication	3.63	.0%	3.46
Drop-in center or day program	2.94	.0%	2.98
AIDS/HIV testing/counseling	3.56	.0%	3.51
TB testing	3.87	.0%	3.71
TB treatment	3.60	.0%	3.57
Hepatitis C testing	3.56	.0%	3.63
Dental care	2.27	29.0%	2.59
Eye care	2.63	.0%	2.88
Glasses	2.81	.0%	2.88
VA disability/pension	3.63	8.0%	3.40
Welfare payments	3.00	.0%	3.03
SSI/SSD process	3.44	.0%	3.10
Guardianship (financial)	2.71	8.0%	2.85
Help managing money	2.75	7.0%	2.87
Job training	3.06	23.0%	3.02
Help with finding a job or getting employment	3.19	38.0%	3.14
Help getting needed documents or identification	3.25	.0%	3.28
Help with transportation	3.19	15.0%	3.02
Education	3.13	.0%	3.00
Child care	2.38	.0%	2.45
Legal assistance	2.88	.0%	2.71
Discharge upgrade	3.57	.0%	3.00
Spiritual	3.38	.0%	3.36
Re-entry services for incarcerated veterans	3.31	8.0%	2.72
Elder Healthcare	3.56	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.79
Co-location of Services - Services from the VA and your agency provided in one location.	1.57
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.07
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.71
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.15
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.71
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.86
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.29
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.00
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.71
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.00
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.00

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.73
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.73

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC San Juan, PR - 672

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 75

2. Estimated Number of Veterans who are Chronically Homeless: (Data not available)

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 75 (estimated number of homeless veterans in service area) **x** **chronically homeless rate** (Data not available) (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	132	20
Transitional Housing Beds	440	0
Permanent Housing Beds	294	50

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 2

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Homeless coordinator will negotiate with emergency shelters in order to attain priority status for homeless veterans.
Transitional living facility or halfway house	Homeless coordinator will negotiate with organizations providing transitional housing to give veterans priority in placement.
Long-term, permanent housing	Homeless coordinator will negotiate with organizations providing permanent housing to give veterans priority placement.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **17** **Non-VA staff Participants: 100.0%**
Homeless/Formerly Homeless: **5.9%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	2.38	9.0%	3.47
Food	2.44	18.0%	3.80
Clothing	2.31	.0%	3.61
Emergency (immediate) shelter	1.94	25.0%	3.33
Halfway house or transitional living facility	2.19	42.0%	3.07
Long-term, permanent housing	2.13	45.0%	2.49
Detoxification from substances	3.81	25.0%	3.41
Treatment for substance abuse	3.75	27.0%	3.55
Services for emotional or psychiatric problems	3.8	18.0%	3.46
Treatment for dual diagnosis	3.7	.0%	3.30
Family counseling	3.63	.0%	2.99
Medical services	3.88	25.0%	3.78
Women's health care	3.75	.0%	3.23
Help with medication	3.44	9.0%	3.46
Drop-in center or day program	3.13	.0%	2.98
AIDS/HIV testing/counseling	3.69	.0%	3.51
TB testing	3.50	.0%	3.71
TB treatment	3.44	.0%	3.57
Hepatitis C testing	3.44	25.0%	3.63
Dental care	3.56	9.0%	2.59
Eye care	3.63	.0%	2.88
Glasses	3.63	.0%	2.88
VA disability/pension	3.50	.0%	3.40
Welfare payments	2.69	.0%	3.03
SSI/SSD process	2.33	.0%	3.10
Guardianship (financial)	3.06	.0%	2.85
Help managing money	3.06	.0%	2.87
Job training	2.19	9.0%	3.02
Help with finding a job or getting employment	1.94	9.0%	3.14
Help getting needed documents or identification	3.00	.0%	3.28
Help with transportation	3.40	9.0%	3.02
Education	2.73	9.0%	3.00
Child care	1.50	18.0%	2.45
Legal assistance	2.75	8.0%	2.71
Discharge upgrade	3.00	.0%	3.00
Spiritual	3.75	.0%	3.36
Re-entry services for incarcerated veterans	2.14	.0%	2.72
Elder Healthcare	3.60	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

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VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.57